Blue Cross HMO℠ – Mod. Plan H17

Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders.

Annual copay maximum: Individual $500; Two-Party $1,000; Family $1,500

The following copays do not apply to the annual copay maximum:

- inpatient hospital services
- infertility services
- inpatient detoxification services

Covered Services	Per Member Copay
Inpatient Medical Services	
➢ Semi-private room or private room if medically necessary; meals and special diets; services and supplies	$250/stay[1]
➢ Special care units	No copay
➢ Operating room and special treatment rooms	No copay
➢ Nursing care	No copay
➢ Drugs, medications & oxygen administered in the hospital	No copay
➢ Blood & blood products	No copay
Outpatient Medical Services *(hospital care other than emergency room services)*	No copay
Ambulatory Surgical Center	
➢ Outpatient surgery & supplies	No copay
Skilled Nursing Facility *(medical conditions & severe mental disorders limited to 100 days/calendar year)*	
➢ All necessary services & supplies *(excluding take-home drugs)*	No copay
Hospice Care (*Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services)*	No copay
Home Health Care	
➢ Home visits when ordered by primary care physician *(limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)*	$20/visit
Physician Medical Services	
➢ Office & home visits	$20/visit
➢ Hospital visits	No copay
➢ Skilled nursing facility visits	No copay
➢ Specialists & consultants	$20/visit
Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by The Primary Care Physician *(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)*	$20/visit

[1]Not applicable to the annual copay maximum

Covered Services	Per Member Copay
Acupuncture	$20/visit
Surgical Services	
➢ Surgeon & surgical assistant	No copay
➢ Anesthesiologist or anesthetist	No copay
General Medical Services	
➢ Diagnostic X-ray & laboratory procedures *(including mammograms, pap smears, & prostate cancer screening)*	No copay
➢ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
➢ Prosthetic devices	No copay
➢ Durable medical equipment including hearing aids *(limited to $10,000/calendar year)*	No copay
Health and Wellness Services	
Preventive Care	
➢ Complete physical exams & periodic routine checkups when ordered by the primary care physician	$20/exam
➢ Well-baby & well-child care	$20/exam
➢ Well-woman exams	$20/exam
➢ Hearing exams	$20/exam
Vision Exams	
➢ Vision screening from primary care physician *(vision screening covers evaluation only; diagnostic & treatment programs, including refractions, from an optometrist or ophthalmologist must be authorized by the primary care physician)*	$20/exam
Health Education and Wellness Programs	
➢ Specified immunizations	No copay
➢ Allergy testing & treatment *(including serums)*	$20/visit
➢ Instruction in health maintenance & wellness	No copay
➢ Health education programs	Possible charge
Emergency Care	
In Area *(within 20 miles of medical group)* **and Out of Area**	
➢ Physician & medical services	No copay
➢ Outpatient hospital emergency room services	$50/visit *(waived if admitted)*
➢ Inpatient hospital services	$250/stay[1]
Ambulance Services	
➢ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay

[1]Not applicable to the annual copay maximum

Covered Services	Per Member Copay
Pregnancy and Maternity Care	
Office Visits	
➢ Prenatal & postnatal care	$20/visit
➢ Complications of pregnancy or therapeutic abortions	$20/visit
Normal Delivery or Cesarean Section, including:	
➢ Inpatient hospital & ancillary services	$250/stay[1]
➢ Routine nursery care	No copay
➢ Physician services *(inpatient only)*	No copay
Complication of Pregnancy or Therapeutic Abortion, including:	
➢ Inpatient hospital & ancillary services	$250/stay[1]
➢ Outpatient hospital services	No copay
➢ Physician services *(inpatient only)*	No copay
Elective Abortions *(including prescription drug for abortion [mifepristone])*	$150
Genetic Testing of Fetus	No copay
Family Planning Services	
➢ Infertility studies & tests	50% of covered expense[1]
➢ Tubal ligation	$150
➢ Vasectomy	$100
➢ Counseling & consultation	$20/visit
Organ and Tissue Transplant	
➢ Inpatient Care	$250/stay[1]
➢ Physician office visits *(including primary care, specialty care & consultants)*	$20/visit
Mental or Nervous Disorders and Substance Abuse	
Inpatient Care	
➢ Facility-based care *(preauthorization required; limited to 30 days/calendar year; the 30 days/calendar year limit does not apply to inpatient detoxification)*	$100/day[1, 2]
➢ Physician hospital visits *(limited to one visit/day & 30 visits/calendar year; the 30 visits/calendar year limit does not apply to inpatient detoxification)*	$35/visit[2]
Outpatient Care	
➢ Outpatient psychotherapy or psychological testing, or substance abuse *(limited to one visit/day & 20 visits/12-month period)*	$35/visit[2]

[1]Not applicable to the annual copay maximum

[2]These exclusions, copays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. In order to receive coverage, services must be rendered by a Blue Cross behavioral health provider. Please see the EOC for complete information.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Blue Cross HMO—(CaliforniaCare) Exclusions And Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying to commit a felony; or (2) by nuclear energy, when the government can pay for treatment.

Experimental or Investigative. Any experimental or investigative procedure or medication. However, if member has a life-threatening or seriously debilitating condition and we determine that the requested treatment is not a covered service because it is experimental or investigative, the member may request an independent medical review as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services Given by Providers Who Are Not With Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:

1. Be known throughout the world as devoted to medical research.
2. Have at least 10% of its yearly budget spent on research not directly related to patient care.
3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).
4. Accept patients who are not able to pay.
5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Chronic Pain Treatment. Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Consultations given by telephone or fax.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a *hospital stay* mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specified as covered in the EOC.

Exercise Equipment. Exercise equipment, or any charges for fitness programs. This includes charges like those from a physical fitness instructor, health club or gym, even if doctor advises the member to change one's lifestyle.

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Hearing Aids. Hearing aids or services for fitting or making a hearing aid, except as specified as covered in the EOC.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any *infertility* treatment including artificial insemination or in vitro fertilization, sperm bank, and any related laboratory tests.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the *medical group*.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem.

Nicotine Use. Programs to stop smoking or the treatment of nicotine or tobacco use.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines.

Nutrition. Food or nutritional supplements except for special food products and formulas that are part of a special diet prescribed by a *doctor* for the treatment of phenylketonuria.

Orthopedic Shoes. Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Sex Change. Sex change surgery or treatments.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

Surrogacy. Any services or supplies given for a surrogate pregnancy (i.e., the bearing of a child by another woman for an infertile couple), unless the member is the surrogate mother.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited, to dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

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Third Party Liability – Blue Cross of California is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

The Power of Blue.[SM]

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